Individual Studies

PSYCHOSOMATIC PROBLEMS IN GENERAL PRACTICE

R. E. PERTH, M.D. (Vienna)
Harrow

The term " psychosomatic " allows more than one interpretation. In its widest sense it may cover all possible momentary conditions, physiological or pathological, of an individual because essentially it implies the product of the interaction between the total individual, Soma (Physis) and Psyche, and environment. In a still wide but already restricted sense psychosomatic means all pathological bodily conditions the origin and course of which are fundamentally determined by the patient's personality and emotional experiences. In its narrowest, and *sensu strictiori* wrong sense, psychosomatic may be understood to mean bodily conditions without any organic substrate which can only be understood by accepting their psychological cause and determination. This group is roughly identical with the category of functional disorders.

This classification becomes quite clear when observed in actual cases:—

Case 1: Mrs. S. is 43 years old. She has a 25-year-old boy, and a 6-year-old girl born after 19 years of vain hopes of another child. She is a quiet, reasonable woman, and a good housewife. Only where the late born girl is concerned does she get fussy, overworried, and anxious. One day she was taking down curtains when little Mary, who was playing in the same room, hurt herself and let out a yell of pain. Instead of looking down from where she stood or of climbing down the ladder, she jumped down, fell on the table, and broke her arm.

Case 2: Thirteen-year-old John had at last been given a bicycle and was practising on it on the empty road in front of the house. He was riding along nicely when he saw suddenly a solitary tree on the other side of the road, and became scared he might hit it. He tried hard to stay on his side of the road, but the harder he tried the more he was pulled as if by a magnet out of his side, over towards the tree. He hit it, and received a gashing laceration of the scalp.

These are two examples of everyday experience, so common that they can barely be called pathological; yet they are not only affected but directly caused by emotional factors. Without accepting debatable extremes which claim every condition, including accidents, infections, etc., to be psychologically determined, it is easy to see that a certain, unknown number of these conditions are definitely of that type.

Case 3: Mr. Q., 55 years old, complained of epigastric pains, vomiting and abdominal discomfort of sudden onset and three weeks' duration. There was no previous history of any disease or stomach trouble, but x ray revealed an active duodenal ulcer. The symptoms began when he was committed for trial for fraud but released on bail. He had defrauded his firm for many years without any ill effects. Until his appearance before the magistrate he had been convinced that the firm would drop the case and would accept refund of the

sum by his relatives. Within a fortnight of his committal he developed a formidable duodenal ulcer.

Case 4: Mrs. W., aged 60 years, had been a widow for five years. She had had no serious disease. Her only daughter, 27 years old, unmarried, became pregnant. When she learnt of it she retired to bed, crying and broken-hearted. Three days later she attended the surgery with signs of left heart failure, from which she recovered on rest and treatment. Six weeks later I saw her again with the fully developed textbook picture of a thyrotoxicosis. After a stay in hospital she is now on propylthiouracil and keeps fairly well.

The *post* or *propter hoc* in these cases shall not be argued: they belong to the second category in which a definite organic condition develops which allows and demands diagnosis and treatment *lege artis medicinae.*

The general practitioner's primary task in such cases cannot be to undertake research into their problematics. Whether the present organic disease was caused originally, or in its course determined, by psychological factors must not interfere with his overriding duty to treat the ill organ according to established methods of medicine.

All patients found to suffer from an " ill organ " have therefore been excluded from the survey though many of them might be psychosomatic within its wider definition. All psychiatric patients, psychoses, hallucinating schizophrenics, etc., have also been excluded, except if they had been under treatment before they developed such a condition, and did so only as a complication of their original psychosomatic complaints.

The survey deals with all those who asked for help because they felt pained or bewildered by something within themselves; something which did not allow a possible physical diagnosis or treatment. The survey is therefore of a peculiar type of patient. They are peculiar because they all complain of more or less distinct pains, and no organic basis can be detected for them. Specialists, laboratories, x rays, etc., fail to detect a diseased organ.

The name he gives to these cases depends entirely on the inclination of the doctor. It is perfectly understandable that these are a nuisance to some doctors who may appreciate and dimly feel that they do not come with the intention to annoy, that there are, somewhere, some forces which drive them to seek help. These practitioners will still feel frustrated in their endeavours and in their aim to give them adequate treatment. Orthodox medicine knows how to treat sick organs, but does not know so well how to deal with the imagination.

It must be some kind of a mental process which produces these pains. The patient comes to the doctor and expects treatment and a name for his pains. The doctor has to give his " illness " some name or to tell him truthfully that there is nothing organically wrong

with him and that " it is the nerves." In either case he will have to give him some treatment to satisfy his urgent needs. The patient will come back either for more of the same medicine or to tell the doctor that the medicine has been doing no good. The doctor may repeat or change the medicine and try again. A most unsatisfactory and enervating process for both parties has now begun; it goes on and on without an end or until the doctor or the patient becomes fed up and either of them terminate their professional relationship; the patient may then find a new doctor with whom to go through the whole procedure all over again, and the doctor will lose a patient and perhaps a whole family from his list. I am convinced that only few consider these cases a nuisance and treat them as such, that more consider them a nuisance but cater in some way for them, and that many recognize them as genuine sufferers and help them. No other profession but medicine is blessed with a blemish like this on its facial beauty. This is not quite correct: priests all over the world have an identical group among their clientele; they know them well—" Les puces de l'Eglise."

A Description of the Survey

The practice is an average suburban one with exclusively National Health Service patients. The practice population (patients list) has stayed at about 2,500 for the last eight years. The area population is typically suburban, middle class. My special interest in psychology is not known in the district and the practice has therefore at no time attracted any special type of patient. The survey covers the last five years of practice.

As there are few reports from general practitioners and because these few record so extremely differing results, it was endeavoured to find:—

(1) how much of a practitioner's work is being taken up by patients without any organic disease, and

(2) what percentage of all ailments and pains suffered by patients is caused by a disturbance of the personality and not of an organ system.

In order to obtain an answer to the first question all attendances at the surgery during three complete, not consecutive, months (October, January, May) were counted. They were then divided into two categories: organic and non-organic. Mere paperwork was excluded from both. Patients who presented " nervous " complaints but also even a trivial organic condition were listed as organic. If a nervous parent brought a child with the slightest organic disease, the whole group was counted as one and organic.

Wherever doubt arose as to assignment, the case was counted as organic.

Cases illustrate best how this classification worked.

Case 5: Richard, aged ten, is the older of two children; he was brought by the mother because she found threadworms in his motion. She is very upset; she regularly inspects the children's motions and insists upon being called by each of them to do it every morning. She complained of the boy's nail-biting and poor appetite. The boy was given anthelmintic treatment, and their visit to the surgery was counted as one, and classified as organic.

Case 6: Mrs. P., one of my psychological patients, works as a part-time saleswoman in a shop in the district. She considers going to work below her dignity, and resented it very deeply when she was asked to put some boxes back on the shelves ; a job usually done by the then absent shop apprentice. She fell from the safe ladder (most likely as a demonstration against such undignified activity demanded from her) and ran to the surgery to complain of bruises, pains, and a sprained ankle. She was given treatment and the attendance was counted as organic.

On the other hand:

Case 7: A 17-year-old lad, M., complained of abdominal pains; they began a fortnight ago but became worse and when seen were unbearable; they were continuous and had kept him awake the night before. He had been suffering from similar attacks the previous year, when he was admitted to hospital, and fully investigated; nothing abnormal was found. This time the examination proved again completely negative. It became evident during the discussion that this time the pains started while he was on holiday camping with a boy friend; they talked a good deal about sexual problems and during the nights practised a number of times mutual masturbation. After two interviews the attacks disappeared completely and have not recurred since.

Case 8: Mrs. H., 34 years old, a very attractive woman, had been married ten years and had two girls, nine and six years old. She complained of headaches and severe pruritus ani and vulvae; this had started four weeks ago and kept her awake at night. There was no history of previous diseases, and examination was negative. Discussion brought to light that she loved her husband very much when they married and still does so. He had always had an early ejaculation during intercourse which gave her, together with manual stimulation, some enjoyment which she had believed was normal sexual satisfaction. Some months ago, she formed a friendship with another woman with whom she discussed sexual matters. She became inquisitive enough to borrow some books from the library; her reading convinced her that her husband had never offered her a chance of sexual satisfaction and that he was a very imperfect lover. She discussed matters with him and gave him to understand how dissatisfied she was. The result was his complete impotence, which still persists. His nightly trying and failing and his subsequent endeavours to make up for it with manual stimulation and manipulation, she finds repulsive; she would rather have nothing to do with him at all and considered moving her bed into another room but does not know how to make it acceptable to him without hurting him. Headaches and irritation coincided with the conflict between desire to move and that not to hurt him. The connection between her problems and symptoms had never occurred to her. Her complaints disappeared after four interviews.

Case 9: Mrs. W., 50 years old, of plain looks but tidy and neat, had been working more than 30 years in one office where she occupied a fair position. She married seven years ago a man a few years younger than herself. She complained of severe pains in the left breast accompanied by heart palpitations. These attacks started six weeks ago and have become progressively worse. The periods are regular, slightly scantier than normal. Examination is negative. The attacks began with her discovery that her husband, who has always been

dabbling at the races, had lost all his savings; the ensuing quarrels led to his leaving her and living with his sister. His leaving coincided with the sudden deterioration of her condition and the rise of her persistent fear of having cancer of the breast. After five sessions (and one interview with the husband, who subsequently returned to her) Mrs. W.'s attacks ceased.

As can be seen from these cases there is no difference made, or classification attempted, between hysteria, anxiety state, functional disorders, psychoneurosis, etc. All these patients appeared in the surgery to complain of, and to get help for, bodily sensations each of which might in itself be caused by physical (organic) disease and none of which could in fact possibly be cured by orthodox medicine or symptomatic treatment.

For the purpose of the survey, and also for theoretical reasons, such cases are considered the manifestation of a disturbed activity of the mind and personality and therefore as the expression of a neurosis. Neurosis, whenever used in the following, is intended to convey such a state of mind, clinically presented predominantly by mental or bodily symptoms, as the case may be.

Analysis of Survey

Of 2,651 surgery attendances 1,214 or 45 per cent were for organic condition and 1,437 or 54 per cent for non-organic.

As each patient may appear under this arrangement more than once in one or both categories, a nominal list of patients who attended with a new complaint was kept under identical conditions during one month (September).

It was found that 68 (47.2 per cent) patients with new organic complaints attended compared with 79 (53.7 per cent) with non-organic.

The next step was to collect from my notes all patients who had been seen and treated during the last five years for complaints for which no organic basis could be found. Their total number was 985. (Table I.)

TABLE I

THE TREATMENT REQUIREMENT OF 985 CASES OF FUNCTIONAL DISORDER

Treatment required	*Number of cases*	
Symptomatic only	277	522
Less than three special sessions	245	
Three or more special sessions	463	
TOTAL	985	

When I began to follow my interest and to give such patients psychotherapy, I soon realized that their number was so great that it was impossible for me to treat them all. I therefore selected patients for treatment according to the personal interest they aroused in me and, also, according to considerations which will be discussed later. For the purpose of this survey a further selection was necessary because some of these patients did not need or receive any real psychotherapy and my notes on them are therefore scanty.

Only those were taken into the survey who needed more than what every practitioner can give: a patient listening to his troubles and worries with sympathetic encouragement and symptomatic treatment of the complaint is still necessary. It is astonishing to see how great a number of these patients will recover sufficiently to cope with their life and difficulties after one or two of such treatments. Those who did not recover with this, but needed three or more special sessions of psychological treatment, are the object of the investigation which follows. They present the not-psychologically-minded doctor with the greatest difficulties. The special sessions lasted 30—60 minutes each, and the patients were given appointments for them outside the surgery hours.

This deliberate selection means that the further survey deals only with the more serious disturbances and ignores completely the great number of milder neuroses who can just manage to cope with life without breaking down. They drag their feet along and only need to sit down for a rest, so to speak, to get their breath back. The serious ones are those who fall at the wayside, and remain there if they do not get some help to put them on their feet again.

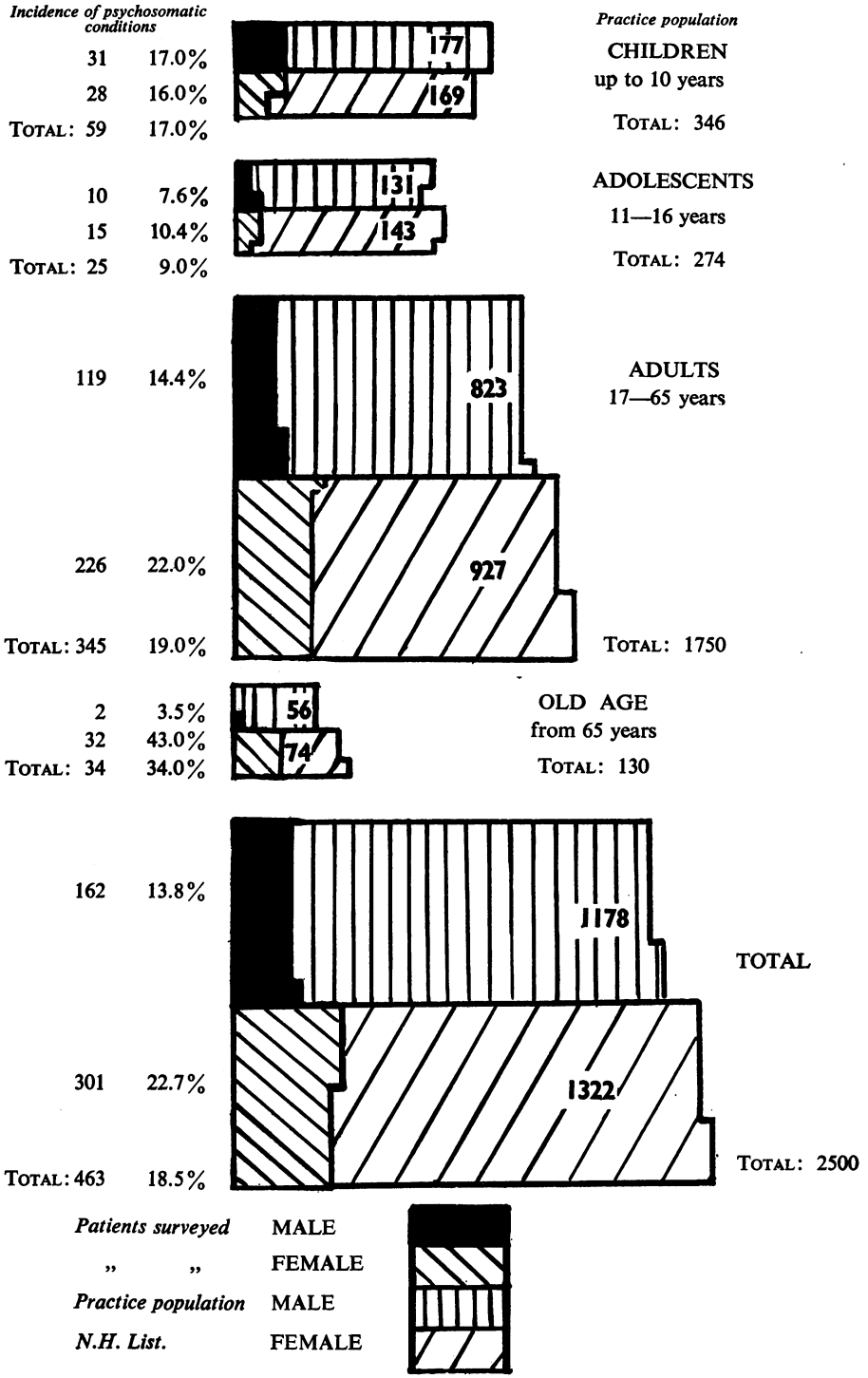
Table I shows that 985 people (40 per cent) out of 2,500 sought help at one time or another during a five-year period for complaints without any organic basis. Almost half of these (49 per cent) suffered so severely that in order to resume their routine life they needed psychological treatment beyond the ordinary scope of a general practice.

More than half (54 per cent) of my activity as a general practitioner was claimed by patients without any organic basis for their complaints. Forty per cent of the total practice population and 53.7 per cent of all patients who attended the surgery during one random month suffered from psychosomatic conditions.

These patients pose many problems besides that of incidence. A number of them is investigated in the following pages. The selection is not dictated by any order of importance but reflects merely personal interest and shows again the different personal approach to the whole matter.

TABLE II

DISTRIBUTION OF PRACTICE POPULATION ACCORDING TO SEX AND AGE AND INCIDENCE OF PSYCHOSOMATIC CONDITIONS



The practice population was broken down into male and female and age groups. Table II shows the incidence of neurotic conditions grave enough to be included within these groups in absolute figures and as a percentage of the practice population in their age groups. The total incidence is 18.5 per cent, i.e., one out of every five of the practice population is suffering from some psychological disturbance of a serious character. Of every five such neurotics three are women, two are men.

As the practice population is a random section of the area population, this figure should be applicable directly to the uniform population of the borough of 123,384 (census 1951) which would give for the five years under survey the formidable figure of 26,475 so seriously disturbed people in the borough that they are unable to do satisfactorily their routine work, be it at school, occupation or home; of these 10,590 would be males and 15,886 females. The same census put the male population of working age at 38,950; our incidence figure of 14.4 per cent for the same age group would indicate 5,453 working men in our borough as being incapable of doing their work properly or at all, not because of physical disease but because of their personality. A fantastic vision if one considers the economical implications.

There is a high incidence of neurosis in old age, an even level among children and adults and a low during adolescence. The high figure of old age was certainly affected by senile changes of the cerebrum, possibly superimposed on some already present neurotic trait. In assessing the low figure in adolescence two factors have to be considered, either separately or in combination. There is the parent's reluctance and adolescent's unwillingness to visit the doctor, together with the adolescent's secretiveness and difficulty of confiding in anyone. There is the corrective and rehabilitating influence of the school as a counter-balance against the effects of the family. The validity of the low figure will depend on which of these two factors is thought to have produced it. It appears to me most likely that both are equally responsible. I don't doubt that the true figure would be at about the level of children and adults.

There is no sex difference amongst children. In all other age groups females preponderate. The difference is definite among adolescents, is fully established among adults and is very great among the old people. This will be taken up again in the discussion.

Fifty-two of the 463 surveyed patients were suffering additionally to the complaint for which they came to the surgery from a condition which was more than merely incidental to their complaint and which fitted into and could be given a conventional diagnostic

TABLE III

CONVENTIONAL CLINICAL DIAGNOSES.

Diagnosis	*Adults*		*Children*		*Total*	%
	Male	*Female*	*Male*	*Female*		
Psychoses	3	15	..	..	18	3.9
Senile involution	2	10	..	..	12	2.5
Epilepsy	2	3	3	1	9	1.9
Mentally backward	..	3	3	7	13	2.7
Neuroses	123	243	25	19	411	89.0
TOTAL	..	..	..	..	463	100

TABLE IV

SHOWING PRECIPITATING FACTORS

Precipitating factors	*Male*	*Female*	*Total*	%
Partus	..	10	10	3.0
Menopause	..	63	63	16.5
Operation	1	..	1	0.3
Housing	..	..	..	0
Disease in family	3	1	4	1.1
Death of spouse	1	8	9	2.2
Emigration	..	4	4	1.0
Financial problems	13	1	14	3.6
Approaching marriage	3	2	5	1.3
Broken-off engagement	..	2	2	0.6
Divorce	5	7	12	3.0
Marital problems	7	19	26	6.8
Long journey	1	..	1	0.3
Crime committed	1	..	1	0.3
No factor obvious	86	141	227	60
TOTAL without children and adolescents	121	258	379	100

label. The remainder (411) could not be labelled and they appear in the Table III under the heading " neuroses " in the meaning described on page 296. The " backwards " were included in the survey because they offer observation of deviation from normal mental behaviour on the background of some existing abnormality.

Table IV shows that in about one-third of all patients an acute, overt difficulty can be found confronting the patients which is too difficult for them to overcome and so precipitates or triggers off their mental breakdown. In about two-thirds, such a trauma is not obvious and is unknown to the patient; then it can only be grasped in the course of psychological interviews when it is found hidden behind and covered up by unconscious defensive fences. The table does not refer to children and adolescents.

It is interesting that men and women appear equally apprehensive when approaching marriage, that women are deeper affected by a broken-off engagement than men, and that both sexes are again equally affected by a divorce. The figures referring to marital problems (which includes unfaithfulness of partner, friction and generally insufficient adaptation) shows the weaker social condition of the female partner at least as much as the questioned innate trend of the female psyche. The same consideration applies to the figures relating to " death of partner." If there are no children, or if they have grown up and left home, the death of the husband leaves the widow stranded in a suddenly emptied world. Conversely the widower has a number of socially acceptable distractions and contacts left for life without a partner. I have seen it happen frequently in both sexes that the surviving partner emerged rejuvenated from the bereavement and appears to have taken a new lease of life from the loss of the partner. In such cases, if a widow was concerned, she was invariably left financially well provided for.

Table V tabulates the symptoms, the somatic disturbances of which the patients complained most frequently and for which they needed help when they originally turned up in the surgery. The total in the table exceeds the total number of patients because some of them complained of more than one symptom. The symptoms in the table are not the only ones which were presented but the most frequent ones: odd though interesting complaints like complete aphonia, " smelly sweat," etc., are not mentioned at all, nor are those which usually accompany an obvious breakdown of the whole personality such as shaking, crying fits, irritability, fatigue, loss of concentration and appetite. The main attention was given to complaints which, however suspicious they might be, could be a sign of a primary, physical disease.

TABLE V

FREQUENTLY PRESENTED SYMPTOMS

Symptoms presented	*Adults*		*Adolescents*		*Children*		*Total*
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	
Sleep disturbance ..	75	154	3	17	12	13	274
Chest pains, lt. side ..	19	68	..	..	..	..	87
Skin condition ..	8	29	2	3	6	3	51
Epigastric pains ..	29	18	1	1	..	..	49
Asthma	6	6	5	1	5	8	31
Choking	3	20	..	..	..	..	23
Migraine	4	14	..	2	..	..	20
Bedwetting	2	1	1	..	12	4	20
Frigidity	..	16	..	..	..	..	16
Impotence	8	..	..	..	..	..	8
Diarrhoea	..	7	..	2	1	..	10
Abdominal pains ..	..	4	1	..	..	..	5
Hay fever attacks ..	..	5	2	4	1	2	14
Headaches	4	6	..	..	..	..	10
Suicidal	2	5	..	..	..	..	7
Pruritus, genital ..	3	27	..	..	..	..	30
Dypsomania	2	2	..	..	..	..	4

Next in frequency and constancy after sleep disturbance come pains in the left side of the chest; in the left breast in women, around the heart in men. This complaint is so constant that it has become for me pathognomonic for psychogenic conditions. There is no other outstandingly constant complaint to indicate the psychological nature of the condition. This means that not the kind of the complaint but their number, their vagueness, the way of describing it, the general behaviour and mood of the patient indicate some fundamental involvement of the psyche.

In studying Table V it must be borne in mind that most cases of long-established (1) gastric and duodenal ulcer pains, (2) asthma and hay fever, (3) chronic skin diseases, and (4) fibrositis are

excluded from the survey. This was done because they have long since settled down to one symptom, the symptomatic treatment of which enables them to carry on and to cope with life in general and with their personal difficulties. To start treatment here, to show these patients the real problems behind their defence screen would break down their now efficient defences, would block escape routes without guaranteeing them a strengthening of their life position. Also the great number of these cases prohibits even contemplating psychological treatment.

To assess their number I went through all specialists' reports referring to the five years of the survey. Those in which no organic cause was found, and are not included in the 463 patients under survey, are shown in Table VI. The number is smaller than the actual number of patients of that type because a number (24) have not been seen by a specialist for a number of years. These 24 were old patrons of the practice already when it was taken over by me; they have been coming regularly for the same medicine on which they had agreed with my predecessor. It is most likely that I suggested to at least some of them an x-ray or specialist examination at one time or another and that it was refused. They make up, together with the 498 patients of Table VI, the 522 functional disorders in Table I. The negative specialists' reports referring to asthma, hay fever and skin diseases are negative with regards to aetiology and therapeutic efficacy.

TABLE VI

WELL-ORGANIZED PSYCHOSOMATIC CONDITIONS

	Male	*Female*	*Total*
Headaches, migraine	15	31	46
Asthma	26	24	50
Hay fever	11	24	35
Fibrositis, etc.	19	51	70
G. & D. ulcer pains	71	41	112
Abdominal pains..	3	22	25
Skin disorders	40	69	109
Heart attacks	41	10	51
GRAND TOTAL	226	272	498

This table reminds one again of how small the number of psychosomatic cases in this survey must be, compared with the total

number among the population. Included are those cases where the treatment of the symptoms would or did not re-establish the patient's ability to carry on with their task. In the cases of asthma, skin diseases, etc., in Table V, symptomatic treatment proved insufficient for the needs of the patients; the complaints recurred and did so regularly only as a response to difficulties, they were so clearly part and parcel of some mental disturbance that the patients or parents themselves could not but realize spontaneously that " it is the nerves, doctor." In all these cases the psychogenic origin of the disorder was worked out during the psychological treatment during which the symptom disappeared or improved.

A most interesting problem is why the patients select the various symptoms and finally settle on one or more of them. This point will be discussed later.

Family Incidence

It was considered of interest to find out, where possible, the structure of the families of neurotics, how many members of the family and how many generations were involved in the build-up of the final situation and how many of the members had to receive actual treatment. Table VII was worked out for this purpose. These patients offered greater opportunities than any others to work out certain theories about the development of neurotic conditions and symptoms.

TABLE VII

SHOWING THE NUMBER OF PATIENTS AND OF GENERATIONS WITHIN 62 FAMILIES WITH PSYCHOSOMATIC COMPLAINTS.

	1 family with 4 generations and	8 patients
	13 families with 3 generations and	41 patients
	48 families with 2 generations and	115 patients
TOTAL:	62 families	164 patients

These theories are supported by the facts observed in families of a quite different structure; namely, when there is one parent a neurotic and the spouse an above average, level-headed, common-sense personality. The effect of such a fortunate situation is (in the 19 families of this type in my material) that the children are mentally healthy, undisturbed, and well adjusted. The neurotic partner (the father in all cases but one) has typical symptoms and history of his or her neurosis and has been or is being treated for

it. The other members of these families are well known to me and those of two families were assessed by personality tests.

Influence of Parental and Home Background

When studying the various constellations of families it becomes clear that the grown-ups are the decisive factors (within the somatic limitations) in the mental development of the children. It can be shown how their individual influences add up or counteract and balance each other. As anywhere else the negative factors are also here more potent in fixing the final level and it needs more than an equally strong positive one to eradicate the other.

By studying the children in simple and complex family situations analysis of the various individual influences of the grown-ups may be made and compared with those found in the children.

TABLE VIII

SHOWING TYPICAL PARENTAL CONDITIONS OF 394 PSYCHONEUROTIC PATIENTS

Parental situation	*Patients*	
Fighting among parents	28	7.1%
Parents divorced	23	5.8%
Parents resented patient	8	2.3%
Parents pampered patient	65	16.5%
Obviously nervous parents	270	68.0%
TOTAL	394	99.7%

In the case of 394 psychoneurotic patients details of parental and home background could be ascertained. Table VIII shows four characteristic patterns of the parents. Two hundred and seventy (68 per cent) neuroses developed in persons whose parents, one or both, had been " highly strung " and had been treated for nervous trouble at one time or another. Twenty-eight (7.1 per cent) witnessed and knew acts of hostility between their parents; 23 (5.8 per cent) experienced early in youth divorce of the parents; eight (2.3 per cent) grew up in an atmosphere of resentment by one or both parents; 65 (16.5 per cent) had had a pampered, overprotected childhood. These figures are a most important result of this survey. They show that manifest neurosis in the parents accounts for 70 per cent of cases of neurosis; they underline the fact that overprotection is responsible for as much neurotic behaviour as all the other parental factors, except their manifest neurosis, taken together. It appears also that divorce has no worse effect on children than

the parents' staying together under whatever marital conditions. There was no psychopath and only one delinquent among the material of the practice.

TABLE IX

NUMBER OF CHILDREN IN 190 FAMILIES WITH 341 NEUROTIC PATIENTS.

Siblings ..	1	2	3	4	5	6	7	8	9	10	11	12	*Total*
Families ..	51	47	32	17	13	6	7	2	5	2	1	2	190
Patients ..	51	80	59	46	27	17	23	7	12	7	7	5	341
Maximum..	51	96	96	68	45	36	49	16	45	20	22	24	..
Incidence %	100	83	61	65	60	45	46	43	26	35	30	20	..
% of Total 341	15.0	23.5	17.3	13.5	7.2	4.8	6.5	2.1	3.8	2.1	2.1	1.6	100

It is said that families with many children are less likely to produce neurotics than those with few. Table IX shows the number of children in the families of 341 patients and apparently confirms this contention. But modern families are as a rule small; the big families belong, therefore, to an older generation and are represented by elderly individuals of the practice population. A fair number of the members of these families are beyond my personal or even the patients' knowledge because they are dead or have been lost sight of. The small families are youngish and all their members may usually be investigated. The siblings who are dead or scattered over the country might have been ill just the same but do not appear in the table. This burdens the figures of the small families.

A few figures of big families illustrate this point.

H.: 10 children; nothing known of 3; 6 reported as suffering from nerves; 1 patient.
T.: 7 children; nothing known of 3; 3 reported as very nervous; 1 patient.
L.: 7 children; 2 reported as very nervous; 5 patients.
B.: 8 children; nothing known of 4; 4 patients.
Hi.: 5 children; nothing known of 2; 1 reported as suffering nervous breakdowns; 2 patients.
A.: 5 children; 3 reported as very nervous; 2 patients.
K.: 7 children; 4 have always suffered from nerves; 3 patients.

Table X shows the exposure of the only, of the first and of the second child in the family and the even chances of the children in other positions among their siblings.

Table XI gives the number of patients who needed specialist treatment, or admission to hospital, or physical treatment. The percentage of physical treatment refers to the total of 125 who received specialists' treatment; the other percentage figures in the

TABLE X

POSITION OF PSYCHONEUROTIC PATIENTS AMONG THE SIBLINGS OF 170 FAMILIES.

	Only child	*First child*	*Second child*		*Last child*	*Between position*
			Same sex	*Opposite sex*		
	No. %	*No.* %	*No.* %	*No.* %	*No.* %	*No.* %
Male	18 5.2	15 4.3	5 1.4	8 2.2	6 1.7	5 1.4
Female	33 9.3	30 8.6	13 3.8	9 2.7	12 3.5	15 4.3
TOTAL ..	51 14.5	45 13	18 5.2	17 4.9	18 5.2	20 5.8

TABLE XI

SHOWING SPECIALISTS', HOSPITAL AND PHYSICAL TREATMENT

Specialists' treatment	*Number*	%
Outpatients dept.	73	15.7
Hospital admission	52	11.2
TOTAL	125	26.9
Of them physical treatment	37	29.6

table refer to the 463 surveyed patients. The number of those referred by me to outpatient departments diminished progressively with growing experience on my part and their average incidence over five years of 1: 6 is not true any more. Those admitted to hospital have been and are still beyond the scope of my competence and facilities. That 30 per cent of all specialists' treatment was physical treatment indicates the shortage of psychotherapists and/or the great efficiency of physical treatment.

Summary and Conclusion

The patients of an average, suburban general practice were investigated and the incidence of " psychosomatic " conditions during a five-year period was recorded. Pains and painful sensations without organic cause which were found to be related to personality disturbances and could be cured or improved by psychological treatment were all called " psychosomatic " and considered an

expression of a disturbed activity of the mind, i.e., a manifestation of a neurosis.

It was found:

Nine hundred and eighty-five persons out of 2,500 or 39.4 per cent suffered at least once during the five years from such a disturbance sufficiently painful to seek medical help.

Four hundred and sixty-three or one out of every five of the practice population needed psychotherapy of some kind to be able to cope again with his routine life be it in school, home or at work.

Half the work during surgery hours was taken up by psychosomatic conditions.

More than half of all fresh complaints brought to the surgery were of psychosomatic nature.

These figures conform broadly with those found by Cassidy, Curtius, Hamman, Halliday, Hopkins, Model, Pougher, Sneddon. They differ considerably from the findings of Frey, Pemberton, Roemer, Rorie, Watts and Watts, and others. These authors vary among themselves as widely as from six per cent and 20 per cent The reason for these discrepancies is the different approach of the various investigators and lack of uniform definitions.

It was further found:

The most common and constant somatic complaint after sleep disturbances are pains in the left side of the chest.

Sixty-eight per cent of all neurotic patients have manifestly neurotic parents and imitate their symptoms with almost photographic exactitude.

This reproduction of the features of the neurosis of their elders can be followed through generations.

Overprotection is, after manifest neurosis of the parents, the greatest single factor in the development of neurosis.

Only, first and second children's contribution to neurosis incidence is more than double that of other children-positions.

The available statistical material could not decide whether the number of children in a family is a significant factor in the development of neurosis.

It was endeavoured to make understandable why patients with psychosomatic complaints are considered nuisance cases by the not-psychologically-minded doctor and why so many people go through life not on solid earth but on phenobarbitone.